Equality and difference: persisting historical themes in health and alcohol policies affecting Indigenous Australians

Maggie Brady

J. Epidemiol. Community Health 2007;61;759-763
doi:10.1136/jech.2006.057455

PUBLIC HEALTH PAST AND PRESENT

Equality and difference: persisting historical themes in health and alcohol policies affecting Indigenous Australians

Maggie Brady

J Epidemiol Community Health 2007;**61**:759–763. doi: 10.1136/jech.2006.057455

Correspondence to: Maggie Brady, Centre for Aboriginal Economic Policy Research, Hanna Neumann Building #21, Australian National University, Canberra ACT 0200, Australia; Maggie.brady@anu.edu.au

Accepted 21 March 2007

Disseminating national health and alcohol policies to Aboriginal and Torres Strait Islander people in Australia has been a challenging task for governments and public servants. This has been for a number of reasons, including the enduring (negative) legacy of past ''Aboriginal affairs'' policies, the fact that Indigenous health programmes and alcohol programmes have been treated separately since the 1970s, and a more recent context in which the recognition of cultural difference was privileged. Confronted with the politics of difference, health departments were slow to examine avenues through which best practice advice emanating from WHO, and alcohol policies such as harm minimisation and early identification and treatment in primary health care, could be communicated in culturally recognisable ways to independent Indigenous services. In addition, there was hostility towards harm minimisation policies from Indigenous service providers, and Indigenous treatment programmes remained largely committed to abstinence-oriented modalities and the disease model of alcoholism, despite moves away from these approaches in the mainstream. However, genuinely innovative acute interventions and environmental controls over alcohol have been developed by Indigenous community-based organisations, approaches that are reinforced by international policy research evidence.

In Australia strategies for dealing with Indigenous health and substance misuse – particularly alcohol misuse – have been influenced not just by policies framed to deal with these specific issues, but by successive nationwide ''Aboriginal affairs'' policies such as protection, assimilation, self-determination and self-management. It is arguably these latter policies that have had a greater impact on the availability and supply of alcohol, and on mechanisms for dealing with alcohol misuse among Indigenous Australians, than those policies targeted at alcohol itself. ''Aboriginal affairs'' policies have influenced Indigenous Australians' attitudes towards the state as well as their responses to key alcohol policies such as harm minimisation. The twin themes of Indigenous equality (the struggle to be treated the same as other Australians, without discrimination) and Indigenous difference (the recognition that Indigenous people have special rights) permeate these policies, and in turn have affected the extent to which the apparatus of state has been able to disseminate progressive strategies and influence service delivery on the ground.

Australia is a federation (proclaimed in 1901) composed of six states and two territories, each with its own government. The national ''federal'' government has, however, gained increasing and often contested power over the last 60 years.

Australia's Indigenous peoples constitute but a small proportion (2.4%) of the overall population, numbering 400 000 people who identify as Aborigines or Torres Strait Islanders. As with the situation in many developing countries,[1] contemporary life for Indigenous Australians is a *bricolage* of varying lifestyles, including those of tradition-oriented remote communities and (the majority) now resident in urban areas (''major city'', ''inner regional'' and ''outer regional'' census categories) One-quarter of the Indigenous population lives scattered across the vast remote areas of the continent where access to goods and services is severely impeded by small numbers and long distances.[2] It is a youthful population, with a median age of 20 compared with 36 years of age for non-Indigenous Australians, but population growth is constrained by persistently high mortality, especially in adults. Most Indigenous people barely reach retirement age, with a 17-year difference in life expectancy between Indigenous and non-Indigenous Australians,[2] and those dying from alcohol-attributable causes have an average age at death of 35 years.[3] Aboriginal and Torres Strait Islander peoples are twice as likely as non-Indigenous people to smoke, to drink at high-risk levels and to use illicit drugs.[4]

ABORIGINAL AFFAIRS POLICIES

Prohibition on supply and consumption was the first alcohol ''policy'' to be directed towards the Indigenous population and it was framed in the nineteenth century as a specifically race-based policy, rather than being instituted for health reasons. It represented a state-imposed and maintained racial hierarchy and, as such, it inevitably and eventually became a civil rights issue.[5] The early colonisation of Australia by the British from 1788 onwards was marked by eager attempts to import and produce alcoholic beverages, followed by (generally unsuccessful) attempts at controlling the number of licensed premises in and around the embryonic town of Sydney in what came to be called New South Wales. Aboriginal people in the region first tasted strong liquor in this period, and those who so desired could gain access to it through exchange, and by importuning the settlers and visiting expeditioners. By 1838 the introduction of intoxicating liquors was deemed to be ''productive of serious evil to the said Aboriginal natives'', and the first legal restrictions on the sale or gift of liquor came into being in New South Wales.[6] By the 1930s the licensing acts of all states of the nation included special clauses prohibiting sales to Aboriginal people; however, as would be expected, illegal trading was widespread.[7] These were protectionist policies driven partly by genuine welfare concern and partly by exaggerated fears of intoxicated and potentially uncontrollable ''natives''. A nation of enthusiastic drinkers, Australia never embraced prohibition for its general population as did the United States, but bans on alcohol consumption by Aboriginal people, and later Torres Strait and Pacific Islanders, continued in various formulations until the 1960s. Even then, special

measures for reserve and mission populations remained in force to protect ''tribal'' Aborigines from what were seen to be the undesirable influences of modern society. For those subject to them, these laws came to represent inequality, exclusion and discrimination and they were bitterly resented.[8 9] The ''natives'' managed to drink anyway, and the need for secretive and rapid illegal consumption is commonly thought to have created an ongoing culture of binge drinking.[10] Many Aboriginal people and Torres Strait Islanders consumed methylated spirits, while others made good use of those among their number who had been issued with exemption certificates and could legally purchase alcohol – people of Aboriginal descent who demonstrated the ''capacity'' to live independently, like white people.[11 12]

The campaign for civil rights and an end to all forms of state-endorsed racial discrimination was waged during the 1950s and 1960s by numerous Aboriginal advancement organisations and was supported by concerned Australians, welfare groups and women's organisations such as the Woman's Christian Temperance Union (WCTU). Many of these organisations were reluctant to be seen to be lobbying specifically for drinking rights,[5] and the WCTU in particular was somewhat compromised. In 1954 the WCTU National Convention had explicitly *opposed* New South Wales government proposals to allow Aboriginal drinking, and in 1960 WCTU meetings made ''… frequent reference to the fact that the attaining of citizenship must expose aboriginal people to the dangers of alcohol''. Members placed trust in efforts to ''see that they are informed about the effects of alcoholic drink on the body''.[13]

Together with the subsequent fragmentary and poorly planned repeal of the various state laws that enacted it, prohibition had a profound and long-lasting impact on attitudes towards drinking and later attempts at prevention. Access to liquor became a symbol of emancipation, equality and full citizenship.[10] Indeed, some Aboriginal people interpreted the new equality as something that needed to be ''activated'' by having a drink.[11 14] Campaigners had hoped that normalising access to alcohol would result in more moderate consumption – that Aboriginal drinkers would become more ''like us'' – and in one sense this was an assimilationist project. However, while national figures are lacking, there is evidence that alcohol-related convictions among Aboriginal people increased dramatically in the year of, and following, repeal.[9] The Indigenous imprisonment rate is now 12 times that of non-Indigenous Australians,[15] and a large body of evidence demonstrates that drug and alcohol abuse is an important cause of Indigenous contact with the criminal justice system.[16] Alcohol-related homicide and suicide have escalated in the years since the repeal of prohibition.[11 17]

The fact that the right to drink was so thoroughly enmeshed with other civil rights has subsequently constricted (but not extinguished) Aboriginal activism targeting the widespread misuse of alcohol – a consequence that will undoubtedly diminish with generational change. It has meant that community moves to control supply always provoke heated debate. Dissenters argue that implementing dry zones or closing down a licensed canteen (even at the request of Aboriginal community residents) denies Aborigines their ''right'' to drink, perpetuates paternalism and fosters drinking as an oppositional act. The history of prohibition policies also compromised Aboriginal spokespeople and leaders, who might otherwise have taken a more public stance by voicing their concerns over the increasingly damaging impact of alcohol on their people, although Indigenous constructions of interpersonal authority and individual autonomy also militate against the emergence of these voices.[8] Unlike Maori leaders in New Zealand[18] and Native American prophets and chiefs[19] who led anti-alcohol movements in the nineteenth and early twentieth centuries, there were few similar Aboriginal campaigners.

A national referendum in 1967 endorsed constitutional change allowing for the federal government to make laws on behalf of Aborigines nationally, although in effect these powers are concurrent with the states and territories; the delivery of health services has always been largely a state matter for all Australians.[20] Legal and constitutional equalities were achieved (after years of outright discrimination and disenfranchisement), in the era of assimilation policies, when Aboriginal people were encouraged to become like other Australians. In the 1960s and 1970s, fearing ''cultural absorption'', Aboriginal organisations and lobby groups rebelled against assimilation and integration, and began to argue for an extra kind of recognition as Indigenous people, culturally distinct from the general population.[21] Under new self-determination and self-management policies of the 1970s, Aboriginal activists established separate community-controlled programmes delivering health, alcohol and legal services, independent of state-run services. These were necessary because of the indifference of ''mainstream'' agencies to the special needs of Aboriginal clients and the failure of general health care services to reach them.[8] The range of community-controlled programmes included residential alcohol rehabilitation centres, usually initiated by untrained, recovered Aboriginal drinkers, to treat people with dependent drinking. These centres were associated neither with state programmes nor with the Aboriginal health services, and were funded separately by the federal government. In the remote settlements, self-determination policies also allowed for the devolution of decision-making to local Aboriginal councils – including making choices about the local availability of alcohol – and also the expectation that they would be able to manage troublesome drinkers themselves. There was some lobbying by government advisors for locally managed canteens that would introduce alcohol in controlled amounts and, it was hoped, in the process help to dislodge the rapid binge drinking patterns of consumption that had developed under restrictive laws.[7] Several of these early attempts at local availability had disastrous results and were curtailed; others continued despite mixed success.[17 22]

ALCOHOL POLICIES AND BEST PRACTICE

From 1985, with the instigation of the first ever National Campaign Against Drug Abuse (NCADA: a cooperative A$274 million national campaign across all jurisdictions),[23]Australian policy was framed around harm minimisation, which was to cause ongoing tension with Indigenous drug and alcohol service providers (at that time dealing mostly with alcohol problems), who believed that abstinence was the only acceptable goal. Australia had a good reputation for its progressive thinking and, like other countries such as the UK,[24] it paid attention to international and local expert opinion, in which alcohol consumption problems were newly conceptualised.[25] In Australia as elsewhere, the historical focus had been on rehabilitating the individual casualties of dependent drinking, but with the disease concept of alcoholism becoming less tenable, the emphasis shifted towards legislative controls, overall prevention and the role of primary health care providers.[26 27] In 1989 NCADA launched a campaign to encourage general medical practitioners to check routinely for alcohol problems and offer brief advice or referrals, and Australian researchers were participants in a WHO cross-national trial of brief alcohol interventions.[28] The NCADA campaign did not, however, attempt to target primary health professionals dealing with Indigenous clients. The Northern Territory (where 28% of the population is Indigenous) instituted its own ''Living With Alcohol'' programme from

1992 to 2000, with funds raised through a levy on all alcoholic drinks with a strength greater than 3.0%. These were used for a variety of treatment, education and prevention activities (for Indigenous and non-Indigenous Territorians), with an emphasis on providing outreach and supporting community action. While endorsing NCADA and the national policy of minimising alcohol-related harm, the Territory government made it clear that certain individuals or groups might decide to live *without* alcohol altogether, and thus strategically acknowledged the views of many Indigenous people. Living With Alcohol started a remarkable period in alcohol prevention in the Northern Territory, and evaluators were able to demonstrate public health and safety benefits as well as a saving of A$124 million as a result of a reduction in alcohol-related harm.[29]

Despite the activities taking place in the Northern Territory, nationally, by the early 1990s, intervention programmes for Indigenous alcohol misuse were fragmented and under-resourced, even with a national campaign in progress that included the goal of improving services for Indigenous people. The broad, best practice treatment approaches that had been debated, trialled and endorsed in the general population did not permeate policy and practice for Indigenous people. This was partly because of Indigenous resistance to ''mainstream'' ideas, but also as a result of underlying structural impediments to the dissemination of good policy advice to the Indigenous sector. Overall, the impediments were threefold: (a) structural barriers within governments; (b) ideological and conceptual barriers within Indigenous organisations; and (c) challenges posed by the politics of Indigenous difference.

Structural barriers within governments

At the level of government, the structural barriers included the ongoing wrangling between federal, state and territory governments over responsibility for health (and alcohol) service delivery that has plagued Indigenous affairs in Australia, a situation tellingly described as ''dysfunctional federalism'' and reflected in Indigenous life expectancies of around 17 years less than those of other Australians.[30] In addition, self-determination policies had spawned separate ''Aboriginal'' or ''Islander Affairs'' departments, funding streams and policy formation mechanisms at each level of government, adding to the ''complicated gavotte'' between the State/Territory and federal governments.[23] Alcohol policies and programming for Indigenous Australians were not lodged within the national health department that formulated these for the rest of the Australian population, and as a result there was a lack of expertise in drug and alcohol issues. As national drug and alcohol policies became more focused and better funded in the mid-1980s, this separation from the mainstream of health expertise began to have an impact. Evaluators of NCADA found that the division of responsibilities between two different levels of government and the poor linkages between NCADA (in the Department of Health) and the national Indigenous body (in the Aboriginal Affairs portfolio) were responsible for slow progress in attending to Indigenous substance misuse problems.[31 32]

Ideological and conceptual barriers in Indigenous organisations

There were ideological barriers to innovation within the ranks of Indigenous service providers on the ground. Indigenous service providers were resistant to and suspicious of harm minimisation policies, which were perceived to provide subtle permission for continued misuse or even to encourage non-drinkers to drink.[32–34] Problems of alcohol abuse *and* dependence continued to be typified as ''alcoholism''. Reinforced by contact with North American treatment activist/consultants,[8] in the early 1990s there was renewed pressure from Indigenous treatment providers for further government expenditure on residential programmes for Indigenous people. These are tertiary treatment, abstinence-oriented programmes largely utilising various formulations of the Twelve Steps associated with Alcoholics Anonymous. One concerned non-Indigenous health professional asked: ''How relevant is current government policy for Aboriginal people if there is a complete rejection of harm minimisation and if abstinence is considered the only solution? ... Are Aboriginal people hearing an indigenous perspective or a North American perspective?''[35] By the mid-1990s, Indigenous people were more likely than non-Indigenous Australians to be receiving residential treatment,[36] and these programmes consumed around half of all national Indigenous substance misuse funding, although in 2000 this had fallen to 34%.[8 37]

For its part, the federal government that funded these programmes directly (by-passing the states) failed to provide management support, build capacity and offer expert direction on broader treatment modalities. While sustaining dense ''internal'' networks between like-minded services,[8] the residential programmes had poor links with outside drug and alcohol professionals and had ideological differences with the Indigenous health services – many of which hinged on philosophical disputes over abstinence. Ultimately, the historically separate development of the alcohol programmes and the health services contributed to delays in integrating alcohol interventions into primary health care, so that implementing these secondary prevention approaches with Indigenous patients lagged behind the general population by more than 10 years.

Accommodating Indigenous cultural difference

Since the 1960s, government policy-makers and departmental officers have been guided by the transformations in Indigenous affairs, moving from an earlier focus on equality, citizenship and integration to an accommodation with increasing demands for the acceptance of Indigenous difference and exceptionalism. For public servants, the politically charged task of managing identity politics means taking account of the need for culturally appropriate interventions, consulting with Indigenous-controlled organisations, and – in keeping with self-determination policies – avoiding the impression that solutions are being imposed from above. In this context there has been an unwillingness to disseminate clear advice based on mainstream best practice research (such as innovative approaches to relapse prevention, motivational interviewing, brief interventions, etc.), because the Indigenous health discourse eschews ''mainstream'' models and stresses a unique identification with culture as a pathway out of addiction with the use of cultural and ''holistic'' approaches within health and alcohol programmes. Bureaucrats were somewhat inhibited by the need for cultural sensitivity and the demands of consultation processes, despite drinking problems of ''an incredible dimension'' (according to one Aboriginal leader)[33] and the majority of Indigenous drinkers consuming at harmful levels.[11]

It is perhaps ironic that the most engaging and successful strategies to manage Indigenous alcohol abuse have developed from the ''bottom up'' as a result of local action, rather than deriving from conscious implementation of institutionally based alcohol policies. These actions are supported largely by non-government Indigenous organisations such as women's and land councils and legal and health services. These provide research and legal support for community campaigns to restrict liquor licences as well as infrastructural support for convening meetings and rallies, and help to organise workshops that produce locally recognisable songs, posters and media

What is already known on this subject

The research reported here examines the extent to which international and national best practice in approaches to alcohol problems has been disseminated to Australia's Indigenous Aboriginal and Torres Strait Islander peoples, and the impediments to such dissemination. Until now there has been little attempt to draw together an analysis of developments over the last 40 years in alcohol policies and Indigenous Australians, although other authors have examined Australian alcohol policies in general and approaches to alcohol problems among Indigenous people.

What this study adds

This study shows that the impediments to the diffusion of a broad range of treatment approaches in alcohol were associated with structural factors within Australian government agencies and the failure of any one level of government to take responsibility for Indigenous health and alcohol services. It also describes how Indigenous resistance to national alcohol policies, as a result of the history of separate funding and service delivery processes, led to a failure to innovate within independent alcohol treatment programmes. It explains how the politics of cultural difference was influential in this respect. Finally, this study shows that ''Aboriginal affairs'' policies often had a greater impact on Indigenous approaches to, and understandings of, alcohol misuse than did designated alcohol policies.

advertisements about drugs and alcohol. Restrictions on the physical availability of alcohol is one example of a policy with international endorsement[38] that has been embraced by Indigenous groups; in rural and remote Australia it has produced measurable and positive results by adjusting hours and days of sale and types of alcohol sold.[39] The Indigenous focus on controls over supply sits in marked contrast to the general trend in Australia, which shows a marked increase in the physical availability of alcohol.[40] Other restrictions, such as declaring individual *homes* (as opposed to whole communities) alcohol-free and acute interventions such as nightly community ''patrols'' seem to be local innovations that serve to reduce harm.[41]

Contemporary public health policies and departmental rearrangements now tend to subsume (and submerge) drug and alcohol issues within broader, ambiguous notions of ''social and emotional wellbeing'', and there is much emphasis on the social determinants of health – developments that appear to have Indigenous acceptance. Australian researchers have been influenced by the new generation of studies into the relationship between poverty, the social gradient, social exclusion and health that gathered pace in the 1990s, and are applying these principles to the poor health status of Indigenous Australians: they fit well with existing Indigenous perceptions of the links between dispossession, discrimination and poor health.[42–44] Since 1995 a conservative national government has dealt with the Indigenous policy arena by closing down representative bodies[45] and relocating responsibilities to mainstream, non-Indigenous departments: policies whose highly political nature is disguised by the objective and rational idioms in which they are communicated.[46] While new policy-forming and advisory committees have allowed for Indigenous input at a federal level, resulting in drug and alcohol policies and strategies complementing those for other Australians,[47] the overall tenor of recent arrangements is suggestive of a retreat from the recognition and endorsement of the special, different needs of Indigenous people, and a return to notions of equal treatment and integration with the Australian collectivity.

ACKNOWLEDGEMENTS

The historical and anthropological research on which this paper is based was undertaken with the support of the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, and the Centre for Aboriginal Economic Policy Research at the Australian National University.

REFERENCES

1 **Room R**, Jernigan D, Carlini-Marlatt B, *et al*. *Alcohol and the developing world: a public health perspective*. Helsinki: Finnish Foundation for Alcohol Studies/WHO, 2002:35.
2 **Taylor J**. *Population and diversity: policy implications of emerging indigenous demographic trends*, Discussion Paper no.283. Canberra: Centre for Aboriginal Economic Policy Research 2006, www.anu.edu.au/caepr/.
3 **National Drug Research Institute**. Trends in alcohol-attributable deaths among Indigenous Australians, 1998–2004. *National Alcohol Indicators Bulletin no. 11*. Perth: National Drug Research Institute, 2007.
4 **Australian Institute of Health and Welfare**. *Statistics on drug use in Australia 2002*. Canberra: Australian Institute of Health and Welfare, 2003.
5 **Chesterman J**. *Civil rights. How Indigenous Australians won formal equality*. Brisbane: University of Queensland Press, 2005.
6 **Bell JH**. Official policies towards the Aborigines of New South Wales. *Mankind* 1959;**5**:345–55.
7 **Beckett J**. Aborigines, alcohol and assimilation. In: Reay M, eds. *Aborigines now:new perspectives in the study of Aboriginal communities*. Sydney: Angus and Robertson, 1965:32–47.
8 **Brady M**. *Indigenous Australia and alcohol policy: meeting difference with indifference*. Sydney: University of New South Wales Press, 2004.
9 **Eggleston E**. *Fear, favour or affection. Aborigines and the criminal law in Victoria, South Australia and Western Australia*. Canberra: ANU Press, 1976.
10 **Elkin AP**. *Aborigines and citizenship*. Canberra: Association for the Protection of Native Races, 1958.
11 **Hunter E**. *Aboriginal health and history. Power and prejudice in remote Australia*. Cambridge: Cambridge University Press, 1993.
12 **Wells JT**, Christie MF. Namatjira and the burden of citizenship. *Aust Historical Studies* 2000;**114**:110–30.
13 **Woman's Christian Temperance Union**. *Minute Books*, Year Ended 1960. Adelaide: State Library of South Australia SRG 186/157).
14 **Bain M**. Alcohol use and traditional social control in Aboriginal society. In:Hetzel BS, Dobbin M, Lippmann L, *et al.*,eds.*Better health for Aborigines?Report of a national seminar at Monash University*. St Lucia: University of Queensland Press, 1974:42–52.
15 **Australian Bureau of Statistics**. *Prisoners in Australia* Catalogue No. 45170.0. Canberra: Australian Bureau of Statistics, 2005:32.
16 **Weatherburn D**, Snowball L, Hunter B. The economic and social factors underpinning Indigenous contact with the justice system: results from the 2002 NATSISS Survey. *Crime and Justice Bulletin* (NSW Bureau of Crime Statistics and Research), 2006;**104**(October):1–16.
17 **McKnight D**. *From hunting to drinking. The devastating effects of alcohol on an Australian Aboriginal community*. London: Routledge, 2002.
18 **Hutt M**. *Maori and alcohol: a history*. Wellington: Health Services Research Centre, 1999.
19 **Mancall PC**. *Deadly medicine: Indians and Alcohol in early America*. Ithaca, NY: Cornell University Press, 1995.
20 **Kunitz SJ**, Brady M. Health care policy for Aboriginal Australians: the relevance of the American Indian experience. *Aust J Public Health* 1995;**19**:549–58.
21 **Attwood B**. *Rights for Aborigines*. Sydney: Allen and Unwin, 2003.
22 **Brady M**, Palmer K. *Alcohol in the outback*. Darwin: North Australia Research Unit, 1984.
23 **Room R**. The dialectic of drinking in Australian life: from the Rum Corps to the wine column. *Australian Drug and Alcohol Review* 1998;**7**:413–437.
24 **Thom B**. *Dealing with drink. Alcohol and social policy: from treatment to management*. London: Free Association Books, 1999.
25 **Lewis M**. *A rum state. Alcohol and state policy in Australia 1788–1988*. Canberra: Australian Government Publishing Service, 1992.
26 **Drew L**. Beyond the disease concept of addiction: drug use as a way of life leading to predicaments. *J Drug Issues* 1986;**16**:263–74.
27 **Ashley MJ**, Rankin JG. A public health approach to the prevention of alcohol related health problems. *Annu Rev Public Health* 1998;**9**:233–71.
28 **Saunders JB**, Aasland OG, Amundsen A, *et al*. Alcohol consumption and related problems among primary health care patients: WHO collaborative project on early detection of persons with harmful alcohol consumption I. *Addiction* 1993;**88**:349–62.

29 **National Drug Research Institute, The Lewin–Fordham Group**. The public health, safety and economic benefits of the Northern Territory's Living with Alcohol program 1992/3 to 1995/6. Perth: Curtin University of Technology, 1999:11.
30 **Kunitz SJ**. *Disease and social diversity. The European impact on the health of non-Europeans*. New York: Oxford University Press, 1994:7.
31 **National Campaign Against Drug Abuse Task Force on Evaluation**. National Campaign Against Drug Abuse 1985–1988. *Report of the NCADA Task Force on Evaluation to the Ministerial Council on Drug Strategy*. Canberra: NCADA, 1989:26.
32 **Office of Evaluation and Audit**. *ATSIC substance abuse evaluation report*. Canberra: Aboriginal and Torres Strait Islander Commission, 1996.
33 **Pearson N**. *Our right to take responsibility*. Cairns: Noel Pearson and Associates Pty Ltd, 2000.
34 **Phillips G**. *Addictions and healing in Aboriginal country*. Canberra: Aboriginal Studies Press, 2003, 129,156..
35 **Mallett L**. Interview with Linda Mallett, Director of the Alcohol & Drug Council of Australia. *Connexions*, 1994;**Oct/Nov**, 18.
36 **Torres MI**, Mattick RP, Chen R, *et al. Clients of treatment service agencies: census findings*. Canberra: Commonwealth Department of Human Services and Health, 1995.
37 **Gray D**, Sputore B, Stearne A, *et al. Indigenous drug and alcohol projects 1999–2000*, Research Paper no.4. Canberra: Australian National Council on Drugs, 2002.
38 **Babor T**, Caetano R, Casswell S, *et al. Alcohol: no ordinary commodity. Research and public policy*. Oxford: Oxford University Press, 2003.
39 **Gray D**, Saggers S, Sputore B, *et al*. What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians. *Addiction* 2000;**95**(1):11–22.
40 **National Drug Research Institute, The Centre for Adolescent Health**. *The prevention of substance use, risk and harm in Australia: a review of the evidence*. Canberra: Australian National Council on Drugs, 2004:35.
41 **Brady M**. *The grog book. strengthening Indigenous community action on alcohol*, Rev edn. Canberra: Department of Health and Ageing, 2005:164.
42 **In: Carson B**, Dunbar T, Chenhall RD, *et al*. eds. *Social determinants of Indigenous health*. Sydney: Allen and Unwin, 2007.
43 **Royal Australasian College of Physicians**. *For richer, for poorer, in sickness and in health … the socio-economic determinants of health*. Sydney: Royal Australasian College of Physicians, 1999.
44 **Tsey K**, Whiteside M, Deemal A, *et al*. Social determinants of health, the 'control factor' and the Family Wellbeing Empowerment Program. *Australas Psychiatry* 2003;**11**:S34–9.
45 **Hunter E**. Commonality, difference and confusion: changing constructions of Indigenous mental health. *Australian e-Journal for the Advancement of Mental Health*. 2004;3: 1–4, www.auseinet.com/journal/vol3iss3/hunterediorial.pdf.
46 **Shore C**, Wright S. Policy. A new field of anthropology. In: Shore C, Wright S, eds, *Anthropology of policy.Critical perspectives in governance and power*.London:Routledge, 1997:3–39.
47 **Ministerial Council on Drugs Strategy**. *National drug strategy. Aboriginal and Torres Strait Islander peoples complementary action plan 2003–2006*. Canberra: National Drug Strategy Unit, 2003.

THE *JECH* GALLERY

Double standards in sex: differences between social expectation and practice among early school leavers

In Hong Kong, premarital, unprotected sex is common among early school leavers.[1] Although sex education can to some extent provide information about safe sex and teach the skills needed,[2] the stigma associated with sex in a wider social context prevents this group from practising it. Chinese culture has historically denounced premarital or extramarital sex, with women's virginity and sexual fidelity being highly prized.[3] Based on the belief that the stigmatisation of sex has resulted from social and cultural values and the filtering of public policy into the daily lives of young people (e.g. a lack of sex education outside school systems), a number of cognitive and behavioural strategies have been developed for adolescents as a means of coping with the stress and social pressure they face in this regard. These strategies aim to help individuals draw a boundary between others' expectation and personal prefrence. By encouraging young people to articulate and express love in ways other than through sex, and by empowering them by, for example, improving their existential and contingency control, they will be able to overcome the stigmatisation associated with sex, and this, in turn, will be effective in promoting safe sex.

Figure 1

W C W Wong
School of Public Health, The Chinese University of Hong Kong

doi: 10.1136/jech.2006.056390

Correspondence to: Dr William C W Wong, Assistant Professor, The Chinese University of Hong Kong, Room 408, School of Public Health, Prince of Wales Hospital, Shatin, Hong Kong; cwwong@cuhk.edu.hk

References

1 **Lam TH**, Janghorbani M, Fan S, *et al*. Hong Kong Task Force on Youth Sexuality Study, Family Planning Association of Hong Kong. Voluntary HIV antibody testing amongst youth in Hong Kong. *Int J STD & AIDS* 2003;**14**(2):132–8.
2 **DiCenso A**, Guyatt, Griffiths WL. Interventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trials. *BMJ* 2002;**324**:1405–64.
3 **Liu H**, Hu Z, Li X, *et al*. Understanding interrelationships among HIV-related stigma, concern about HIV infection, and intent to disclose HIV serostatus: A pretest posttest study in a rural area of eastern China. *AIDS Patient Care and STDS* 2006;**20**(2):133–42.